**UNPUBLISHED**

**IN THE UNITED STATES DISTRICT COURT**
**FOR THE NORTHERN DISTRICT OF IOWA**
**WESTERN DIVISION**

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| CHRISTA J. ANDERSON,<br><br>Plaintiff,<br><br>vs.<br><br>JO ANNE B. BARNHART,<br>Commissioner of Social Security,<br><br>Defendant. | No. C02-4071-MWB<br><br>**REPORT AND RECOMMENDATION** |

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## *I. INTRODUCTION*

The plaintiff Christa J. Anderson ("Anderson") appeals the decision by an administrative law judge ("ALJ") denying her application for Title XVI supplemental security income ("SSI") benefits. Anderson argues the ALJ erred in finding that her subjective complaints were not credible, that she retains the capacity for light work, and, in general, that she is not disabled. (*See* Doc. No. 10)

## *II. PROCEDURAL AND FACTUAL BACKGROUND*

### *A. Procedural Background*

On September 11, 2000, Anderson filed an application for SSI benefits with a protective filing date of September 6, 2000. (*See* R. 11, 99-101) In her application, Anderson alleged a disability onset date of May 1, 1991. (R. 99) The application was denied initially on February 21, 2000 (R. 75, 77-81), and on reconsideration on May 25, 2001. (R. 76, 86-89) Anderson requested a hearing (R. 90-93), which was held before ALJ Robert Maxwell in Spencer, Iowa, on January 15, 2002. (R. 28-74) Attorney David Scott represented Anderson at the hearing. Testifying at the hearing were Anderson; James P. Farrell, a friend of Anderson's; and Vocational Expert ("VE") Dr. William B. Tucker.

On January 28, 2002, the ALJ ruled Anderson was not entitled to benefits. (R. 8-23) The Appeals Council of the Social Security Administration denied Anderson's request for review on June 19, 2002 (R. 4-5), making the ALJ's decision the final decision of the Commissioner.

Anderson filed a timely Complaint in this court on August 15, 2002, seeking judicial review of the ALJ's ruling. (Doc. No. 1) In accordance with Administrative Order #1447, dated September 20, 1999, this matter was referred to the undersigned

United States Magistrate Judge pursuant to 28 U.S.C. § 636(b)(1)(B), for the filing of a report and recommended disposition of Anderson's claim. Anderson filed a brief supporting her claim on May 16, 2003. (Doc. No. 10) The Commissioner filed a responsive brief on June 27, 2003. (Doc. No. 11) The matter is now fully submitted, and pursuant to 42 U.S.C. § 405(g), the court turns to a review of Anderson's claim for benefits.

### *B. Factual Background*

#### *1. Anderson's testimony and remarks*

Anderson was born on October 30, 1950. She lives alone in Primghar, Iowa, where she has lived all of her life. She made average grades in high school, and graduated in 1968. (R. 32, 62) She has taken a few nurse's aide classes, but otherwise has had no training or education since high school. (R. 33)

Anderson began working at a nursing home at age 16, and continued working there after she graduated from high school. She had a son in 1974, and she quit working in November 1974, to care for her son full time. She has worked very little since leaving the nursing home job. She worked part-time on a few occasions, riding as a supervisor on a Head Start school bus. She worked at that job during the entire school year from September to May, possibly in 1991 or 1992; from January to May on an earlier occasion, but she could not state the year; and from September to January on a third occasion. She worked for six months or less at a TV repair shop, dusting and cleaning up. She was unable to run the cash register because she "screwed up." (R. 33-38) Anderson thought the last time she worked was in 1993. (R. 39)

Anderson stated she is able to stand for ten or fifteen minutes at a time, and then she sits down and rests. She has sharp pain in her lower back and legs, "brought on by

moving, walking, whatever." (R. 41) She explained that she can sit longer in some types of chairs, like the solid oak rocking chair she has at home, than she can in others. (R. 40)

Anderson also said her ability to walk is limited, explaining:

> If I don't do a whole lot at home, sometimes I take it easy and stuff, I can go outdoors, and I start walking, just to go get the mail or uptown, which is about I'm guessing four blocks. I take my time and go easy, and by the time I get up there, I am hurting, it hurts, I have to slow down and take it easy, and then I just go do what I have to do and then come back, and then when I get home, I sit in my chair again.

(R. 41) Her pain from walking is all the way across both hips, and in both legs from her hips to her feet, with the right leg being worse than the left. She stated she has groin pain when she walks, and the sciatic nerve in her right hip bothers her off and on. (R. 42) Anderson stated she does not take pain medication because it does not help. She tried "a sort of Darvocet," beginning with a half tablet and increasing the dosage to two pills at a time. The pills were supposed to last six to eight hours, but hardly lasted four hours, and the next day she would be sleepy and groggy. She quit taking the pain medication about a year before the hearing, and stated, with regard to the pain, "I just ride it out." (R. 43)

Anderson also testified about pain in her neck that causes headaches and makes her arms and hands hurt. The pain is an aching pain that starts in the back of her neck and travels down through her shoulders and into her hands. The pain is on both sides and usually is equal bilaterally, although sometimes, depending on what she is doing, her left hand will hurt worse than her right. (R. 44-45) Activity makes the pain worse. When she does dishes or laundry, she sometimes has pain coming up from her thumbs, sometimes has no pain at all, and sometimes has shooting pain. She stated that at times she is unable to write due to the pain. Anderson is right-handed, and she stated her neck

and arm pain is usually more severe on the right side.[1] (R. 45) She has chronic weakness in her wrists from falling on them, and she is unable to put much weight on her wrists without them buckling. (R. 50-51) Anderson stated she was "very uncomfortable" during the hearing, and she sat with her hands resting up on the table in front of her, which she stated was a comfortable position. (R. 41, 56)

Dr. Lionel Herrera, a neurosurgeon in Sioux City, to whom Anderson was referred by a physician's assistant, told Anderson surgery on her neck and low back might alleviate some, but not all, of her pain; however, she probably would have a 15% to 20% restriction. (R. 46, 51) Anderson last saw Dr. Herrera in the summer of 1997, and she was unwilling to consider surgery at that time. (*Id.*) Dr. Herrera listed Anderson's symptoms in order of severity as (1) neck pain, (2) bilateral shoulder pain, left greater than right; (3) lower back pain; (4) right hip pain; (5) right leg pain; (6) left hip pain; (7) left leg pain; (8) upper back pain; (9) numbness in both hands; and (10) headache. Anderson disagreed with the order of severity, stating instead that Dr. Herrera was simply listing her symptoms from the head down. She stated her worst pain starts in her lower back, and as of the time of the hearing, her leg pain was the most severe, with occasional numbness in her toes. (R. 47-48) Dr. Herrera gave Anderson an epidural flood that, according to Anderson, "lasted maybe four or five days." (R. 51) When she left the doctor's care, he did not prescribe any pain medication, but sent Anderson to the pain unit at Marion Health Center. (R. 48-49)

In 1993, Anderson saw Dr. Quentin Durward, a neurosurgeon in Sioux City. Dr. Durward gave Anderson "a brace that come[s] around the lower back, come[s] to the

[1]This appears to directly contradict her response just a few moments before that the pain is sometimes worse in her left hand than in her right. The court is unable to determine whether Anderson was describing two different types of pain, or she simply misunderstood one of the questions.

front with Velcro strips, . . . [and has] a heavy plastic thing that's formed to your lower back stuck in a pouch." (R. 49) She wore the brace for over a year, but stopped when it quit working. (R. 49-50)

Anderson has had little medical treatment since 1998, when her youngest child left home, due to lack of funds. (R. 50) At the time of the hearing, Anderson was taking Flovent and Serevent inhalers and Albuterol for asthma, Prempro "for menopause" (R. 54), and Celexa "for anxiety." (*Id.*) She stated she had just added Allegra-D for her allergies, and the antibiotic Cephalexin for a respiratory infection. (R. 51, 54) She stated she had been hospitalized or had gone to the emergency room because of breathing difficulties in 1996, but she has not had similar episodes since that time because she has "tried to be very careful." (R. 61)

Anderson's current medications were prescribed by Jackie Kramer, a physician's assistant "at the clinic." (R. 52) She stated the inhalers were samples. She was given some samples of the Allegra-D, and she stated her mother was paying to have the prescription filled. According to Anderson, the clinic gives her three months of Celexa and Prempro at a time, and because of "some kind of medical thing through the clinic," she does not have to pay for those medications. (*Id.*, R. 55) Anderson testified she had only seen the physician's assistant in the year preceding the hearing. She had not tried to see the doctor because she has no insurance. (*Id.*; R. 60)

Anderson stated the Celexa settles her down so she can "get through the day" and "function a little bit better." (R. 55) She worries less "about everything and everyone." (*Id.*) She testified she had started seeing mental health professionals "back somewhere in the 60's," but had not been under the care of a mental health professional for about seven years. (R. 60) She then clarified that the professional she had seen may have been

a social worker rather than a psychologist or psychiatrist. It was someone through Lutheran Social Services who came to her home to counsel her and her son. (R. 60-61)

At the hearing, Anderson's attorney noted her voice sounded raspy. She explained she had been on antibiotics for a few days for symptoms of coughing, runny nose, headache, and pain in her face and chest. She stated the day of the hearing was the first day she had begun feeling somewhat better. (R. 53) Anderson stated she would be unable to work where she would be exposed to dust, wind, cold, warmth, or humidity. She explained she is allergic to dust mites, mold, mildew, and ragweed. (*Id.*)

Anderson stated she does not have a driver's license, and her friend Jim (who testified at the hearing) drove her to the hearing. (R. 56, 57) She has no source of income. Her bills are paid by her 81-year-old mother, Ethel I. Miller, and Jim. (R. 56)

Anderson described her typical day as follows:

> Well, in the mornings, about 10 minutes to 7:00, I get up, because my son and our daughter-in-law bring me my granddaughter in the mornings. She just turned two yesterday, so sometimes she'll go to sleep when she gets there and sometimes she don't. . . . I watch her [for them.] She's – walks . . . now, I don't have to pick her up, I don't pick her up any more than I have to. She's pretty good at playing by herself and she even tries to help me when I'm hanging up laundry and stuff like that. She always runs off with my clothespins and stuff, but she tries to help me and she makes my day. She makes me feel like I'm worth, you know, like it's worth doing something. . . . I don't get paid like I should, but she's my granddaughter.

(R. 57) She stated she does most of her own cooking, cleaning, and housework without assistance, but she has to vacuum sitting on the floor. (R. 59)

Anderson testified she has taken care of her granddaughter since the child was "about four or five weeks old." (R. 58) At first, she watched the baby for ten to twelve

hours a day because of the jobs her son and daughter-in-law had. Anderson had a bassinet beside her bed and she would "sit on the bed and move her back and forth and whatever I had to do." (*Id.*) She explained, "[W]hen I held her, I was on the bed, so if I had to lay her down, I could lay her down and wouldn't [have] to worry about dropping her." (*Id.*)

At the time of the hearing, Anderson was watching her granddaughter from about 7:30 a.m. to 5:00 p.m. each day. She stated she was supposed to get paid for babysitting, but that did not always happen. (*Id.*) She does not care for any other children, and stated she was only caring for this child because it is her grandchild. (R. 59)

At the time Anderson filed her application for benefits, she completed a detailed Disability Report/Adult. (R. 109-18) In the Remarks section of the form, Anderson summarized the basis for her claim as follows:

> I was taken off Title XIX 6-98 when youngest son graduated from high school in May. I had no income, no insurance. Totally dependent on Jim [Farrell] for everything (bills, food, etc.)
>
> I get samples of inhalers for my asthma (Serevent & Flovent) from Jackie at the clinic.
>
> Started getting anxious in July '98 after my youngest son David went into the army, tried to deal with it on my own but couldn't. Jim found me one day in Nov. '98 at my house sitting in a chair holding my arms in my lap, crying. Took me to see Jackie Kramer, N.P. [at] my family doctor. She put me on Celexa for anxiety and Propox/Apap for the pain. Before that, both my sons had come home and found me sitting in my chair crying because of the pain. I was put on Tylenol 3 with codeine then. But didn't help much. I've also been treated for depression with medication in the past.
>
> I still have asthma & allergies.

> For about the last five-six months the sciatica [sic] nerve in my right hip has been giving me a whole lot of pain and discomfort and I never know when it's going to act up. Have more pain across my lower back, all the way down my right leg, to my foot, causes charliehorses [sic] behin[d] my knee, back of my leg and in the instep of my foot, some numbness in my foot.
>
> On my last visit with Dr. Herrera [he said] surgery could be done on my upper and lower spine. I would have about 15-20% restricted movement of my head and neck and a lot of the pain in my arms and hands, etc. would still be there. As for my lower back, my spine might look straight, but I could end up with worse pain than I have now. He told me <u>not</u> to have the surgery until it got so bad I could no longer tolerate the pain. Even if I could have the surgery, I'm not willing to take that risk. Every day I have some pain, I've tolerated it so far. At home I can stop and sit when it gets too bad, I can set my own pace in getting things done. I walk on my own, without any devices, it hurts but I do it anyway, I take my time. A lot of nights I don't get much sleep because I hurt. Sometimes the medicine takes an hour before it starts working.

(R. 117-18, dated 9-15-00)

Anderson also completed a Supplemental Disability Report in which she described her daily activities. (R. 123-25) She reported going out to visit her aunt in a nursing home, her mother, and friends, staying between one-half hour to five hours, depending on the circumstances. She also attends church. In response to a question about how her condition has changed her relationships, Anderson stated her family and friends "are a little more considerate and informed or aware of what I can do." (R. 123)

Anderson reported that she lives alone, and she does all her own cooking and household chores. She reported washing dishes, doing a load or two of laundry a couple of times a week, taking out the garbage twice a week, and vacuuming. She stated she

does things "automatically without even thin[k]ing about it." (*Id.*) She stated her ability to care for herself has not changed since the onset of her problems. (R. 125)

Anderson reported she would like to spend more time with her grandchildren, "but they wear me out – don't walk as far or as long as I could 7 or 8 years ago." (*Id.*)

Anderson completed a Personal Pain/Fatigue Questionnaire on October 3, 2000. (R. 126-29) She reported pain in her lower back, right hip, neck, shoulders, arms, wrists, and fingers, with her pain being exacerbated by movement and changes in the weather. (R. 126) She stated she aches to some degree all the time, but was unable to state how often she would have pain in each specific area, stating, "I just deal with it as it comes." (*Id.*) Her pain will start in one area and then move to other areas. For example, pain in her hands and wrists will move up her arms to her shoulders, or vice versa. (*Id.*) She reported her pain had worsened in the preceding year, becoming more frequent and occurring even when she is at rest. (R. 127)

Anderson listed her pain medication as "Propoxp/APAP 100/650," stating she took one tablet every six to eight hours as needed. She listed no side effects from the medication. In addition to medication, Anderson relieved her pain through self massage; sitting in a high-backed, padded chair, or on the bed against pillows propped against the wall; and, occasionally, using a heating pad. (*Id.*) Activities she has had to stop due to pain or fatigue include running; riding a bicycle; carrying a laundry basket, especially containing wet clothes; and she does not "do a lot of baking or cooking anymore," and is unable to walk as far as she could previously. (*Id.*)

She listed sleep difficulties due to pain, but stated that other than slowing her down at times, pain did not cause her difficulty in her ability to care for herself. (R. 128) She described her typical day as follows:

> Get up, let the cat out on his leash, take my medications[;] if there is laundry to fold, do that[;] if I have my granddaughter, change and feed her, she either goes back to sleep or we go into playpen or her walker. Maybe do a load of laundry, wash dishes, if it's warm outside open up windows, then TV on, don't always watch it – pick up and straighten things up, sort through bills and papers, pick up garbage and empty waste bags – Sometimes do some dusting – walk uptown to get the mail[,] sometimes watch TV in the evenings – if on a weekend when Jim is home or go visiting friends out of town – do some grocery shopping[.] [A] typical day? [E]very day isn't the same.

(R. 129)

Anderson stated she "can lift about ten pounds or less without too much trouble." (R. 128) She can no longer sit at a sewing machine and sew, and she has difficulty mending clothes by hand, holding a needle, buttoning buttons at times, and picking up silverware at times. She cannot hold a laundry basket, but slides it across the floor. (*Id.*) She can walk one to two blocks before she starts hurting, and she can stand for about half an hour at a time. Riding in a car bothers her shoulders and neck. The amount of time she can sit before having pain depends on the type of chair or surface on which she is sitting (*e.g.*, upholstered, wooden, etc.). (R. 129)

### *2. Testimony of James P. Farrell*

Mr. Farrell is 62 years old, and has known Anderson for about 15 years. (R. 62-63) He lives next door to Anderson, in Primghar. (R. 67) He confirmed he has helped Anderson "quite a bit" with her bills, although his income has declined due to health problems, so he is not able to help her as much as he used to. (R. 63) He confirmed that Anderson does not drive at all. (R. 63-64) He drove her to the hearing, and he takes her to the grocery store. (R. 63, 66)

Mr. Farrell stated he has witnessed Anderson having pain in her back, arms and legs, almost on a daily basis. According to him, Anderson frequently has leg spasms. (R. 64-65) He has taken Anderson to the hospital or clinic once or twice "because she was actually hurting so bad that she was crying." (R. 65) He thought Anderson's son also had taken her to the clinic on one occasion for the same reason. (R. 66)

Mr. Farrell and his 10-year-old child mow Anderson's lawn and "pick up some of the weeds and whatnot and stuff like that." (*Id*.)

### *3. Anderson's medical history*

A detailed summary of Anderson's medical records is attached to this opinion as Appendix A. Anderson's medical history is very sketchy from 1988 to 1993, and the Record contains no records at all from September 1993 to March 1994; from December 1995 to March 1997; and no treatment records after June 1997. The evidence of record indicates Anderson's primary complaints fall into three areas: (1) asthma, with related bronchitis, sinusitis, and allergy symptoms; (2) pain in her neck, shoulders, back, hips, and legs, and numbness in her hands; and (3) depression. The court will summarize the Record regarding each of these areas.

#### *a. Asthma*

Anderson apparently began receiving allergy shots at some point. Records from the Ohme Medical Center indicate she received injections on June 22, July 7 and 21, and August 4, 1994, with no reaction. (R. 206)

Anderson sought treatment on August 15, 1994, for bronchitis. Constance J. Lorenz, D.O. prescribed Keflex, Phenergan with Codeine, rest, and fluids. (*Id*.) Anderson returned to the doctor's office on September 21, 1994, and saw Betty Wittrock,

a Physician's Assistant, who diagnosed Anderson with an upper respiratory infection ("URI"), and bronchitis with an asthmatic component. Ms. Wittrock noted Anderson had "a lot [sic] of allergy problems," and she had "taken allergy injections in the past." (R. 205) Ms. Wittrock prescribed Prednisone, Keflex, a Proventil inhaler, and plenty of fluids. (*Id.*)

Anderson returned to see Ms. Wittrock a week later for follow-up. Anderson had run out of her Proventil pills two days earlier, and she had not used her Proventil inhaler as directed. Anderson was given Susphrine in the doctor's office, and her symptoms began to improve; she was breathing much better and feeling better. She was directed to finish the Prednisone and antibiotics, and to make sure she had plenty of Proventil pills and did not run out. (R. 205) Anderson's URI had not resolved by her next visit to the medical center on October 6, 1994. Dr. Lorenz noted Anderson was a smoker. The doctor decreased the dosage of Proventil Repetabs because Anderson was experiencing side effects, and also prescribed a Z-pack, Novahistine DH, rest, and fluids. (R. 204) Anderson returned to the medical center for a follow-up on October 12, 1994. She was feeling much better and doing well with the Proventil inhaler. She was directed to finish her medications and let the doctor know how she was doing. (*Id.*)

Anderson saw Dr. Lorenz again on November 22, 1994, complaining of head pressure and a cough. The doctor noted, "Patient is a known case of wheezing and also has a long history of allergic rhinitis." (R. 203) The doctor prescribed Cephalexin, and changed Anderson's sinus medication from Seldane-D to Entex LA. (*Id.*) A month later, Anderson returned with similar symptoms, and Dr. Lorenz diagnosed probable bronchitis. The doctor directed Anderson to continue taking her current medications, and again prescribed Cephalexin, noting they would change antibiotics if Anderson had not improved in 48-72 hours. (R. 203) Her symptoms apparently resolved at that point, but

then they returned in late February 1995, when she went to the medical center complaining of cough, right ear pain, and head congestion. (R. 202)[2] Physician's Assistant G.A. "Sam" Schwickerath prescribed Erythromycin, and told Anderson to humidify her home, increase her fluid intake, and use Tylenol for pain. (*Id.*)

On March 29, 1995, Ms. Schwickerath saw Anderson for symptoms of coughing, right ear pain, and headache. Anderson was diagnosed with otitis media, sinusitis, and bronchial asthma. She was treated with a MaxAir auto inhaler, and within 15 minutes, her wheezing had subsided, but she still had tightness in her chest. She was given an Albuterol updraft treatment, which gave her definite improvement. Ms. Schwickerath stressed to Anderson that smoking was a definite irritating factor of asthma. She gave Anderson a home nebulizer unit with Albuterol premix, a Prednisone burst inhaler, a MaxAir auto inhaler, and Ceclor. Anderson was instructed to do peak flow readings three times per day, and return in 48 hours for follow-up. Anderson also was given samples of Claritin-D for her sinuses. (R. 197, 199)

When Anderson returned on March 31, 1995, she reported marked improvement, but she still had an occasional spasmatic cough. She returned for follow-up exams on April 2 and 4, 1995, and records indicate her bronchial asthma was resolving. Her peak flow readings averaged 360-390, whereas they had averaged only 240-300 on March 29th. She was given a prescription for a peak flow meter and a nebulizer unit. (R. 197-98) At a follow-up appointment on April 19, 1995, Anderson reported her asthma was "doing much, much better," and she felt it was "cleared up." (R. 198) She was told to continue her current medications, and she was referred to another doctor to treat her earache. (*Id.*)

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[2]In the interim, Anderson continued to obtain refills of prescriptions for Paxil and Entex LA. (*See* R. 202)

Anderson obtained refills of Prednisone Burst, MaxAir auto inhaler, Albuterol Updraft, Claritin D, and Biaxin on April 22 and August 22, 1995. Records indicate some exacerbation of her asthmatic symptoms in August 1995. (R. 197)

On August 23, 1995, Rex J. Jones, D.C. prepared an opinion letter for Disability Determination Services ("DDS") in which he opined Anderson could lift/carry 20 pounds occasionally and five pounds frequently. He stated she could not walk extended distances. He observed Anderson "should be an excellent client for some type of vocational or rehabilitation retraining program in which she can do some type of sitting activity." (R. 86-87)

Anderson saw Ms. Schwickerath for another follow-up exam on September 1, 1995. Records indicate Anderson's acute asthmatic exacerbation was resolving. She was breathing easier and had less coughing. (R. 196)

Anderson had a pulmonary function study on October 12, 1995, with normal results. (R. 191-94) On October 19, 1995, she again returned to see Ms. Schwickerath with symptoms of bronchitis and sinusitis with an underlying allergy component. Ms. Schwickerath noted Anderson "came in early this time," and perhaps she could avoid another URI. Notes also indicate Anderson was on N-said therapy for jaw pain due to dental carries, which "could definitely be an aggravating cause" of her asthma. (R. 190) At her next follow-up exam on October 24, 1995, Anderson was back to full activity, doing well, and having no further episodes of coughing or spasms. She was directed to continue using the Seravent inhaler, Aerobid inhaler, and MaxAir auto inhaler, as well as Bromfed. (R. 189)

Anderson contracted another URI in December 1995. On December 14, 1995, Ms. Schwickerath noted Anderson's infection would be treated "aggressively as she gets into trouble very rapidly." (R. 188) Medications were prescribed, and Anderson was

told to begin taking peak/flow readings as soon as she becomes symptomatic; notes indicate "she doesn't do these on a regular basis even though she's been instructed to do so." (*Id.*) Ms. Schwickerath suggested Anderson see an allergist to be tested so she could control her frequent URIs. (*Id.*) At a follow-up appointment on December 19, 1995, Anderson was doing well and her lungs were clear. (*Id.*)

The Record contains no further evidence relating to Anderson's asthma or allergy problems.

***b. Back, neck, leg, and other pain complaints***

In a partial opinion letter dated December 9, 1993, Constance J. Lorenz, D.O.[3] recites a history of Anderson's low back pain beginning in 1988, when she was diagnosed with a spondylolithesis (*i.e.*, a slipped vertebra) at the L5/S1 level. (R. 207) She apparently did not see a doctor again about the condition until January 1991, and next saw a doctor in August 1991, when a prescription for the pain medication Parafon Forte was refilled, and she was told to use heating pads on her neck and back. (*Id.*) Anderson waited another year before again seeing a doctor, in August 1992, still complaining of back pain. At that time, she reported achiness and pain in her legs when she moved, especially when she walked any distance. The doctor "continued" Anderson on Motrin, indicating she must have seen a doctor previously but the Record is silent in that regard. The doctor also started Anderson on Zoloft. (*Id.*) At Anderson's next visit, she reported the Zoloft had not helped, and she was switched to Amitriptyline, which apparently improved Anderson's sleeping pattern. A repeat X-ray showed the same spondylolitheses at L5/S1, and no problems in Anderson's cervical neck. She was referred for an

[3] *See* Appendix, p. A-5, note 1.

orthopedic evaluation, and was directed to continue taking Amitriptyline, Motrin, and Parafon Fore. (*Id.*)

In September 1992, Dennis Nitz, M.D. performed a nerve conduction test, apparently to test Anderson for carpal tunnel syndrome. The nerve conduction study was normal. (R. 178)

In April 1993, Anderson was evaluated by Quentin J. Durward, M.D., a neurosurgeon. Anderson complained of diffuse spinal pain, numbness and weakness of her upper extremities, and intermittent pain in her lower extremities. Her physical examination was unremarkable except for "some mild wasting of the hand intrinsics bilaterally but not in a specific pattern." (R. 184) She had full range of motion of her neck on forward flexion/extension, rotation, and lateral flexion, and full range of motion of her back in flexion to 90 degrees, although her extension was limited by about 50% due to low back pain. She had unrestricted straight-leg-raising, and no foraminal encroachment. Dr. Durward noted, "This woman is a bit of a mystery. She has a lot of pain complaints but very little objectively other than this hand intrinsic wasting and that she has a general tendency to hyperreflexia." (R. 185) He ordered an MRI and X-rays, and noted a formal neurological consult might be in order.

An MRI of Anderson's cervical spine performed on June 17, 1993, indicated the following:

1. Mild bulging annulus C5-6 and C6-7 without focal disc protrusion, cord compression or foraminal encroachment.
2. Mild reversal of the cervical curvature C3-C5.
3. Focal bright 3mm. area of increased T1 signal intensity dampened on T2 in the posterior superior C6 vertebral body.

(R. 181) X-rays of Anderson's lumbar spine taken the same day showed a narrowed disc space at L5-S1, and some displacement of L5 upon S1, but otherwise normal alignment.

(R. 182) X-rays of her cervical spine indicated scoliosis centered at C4, convex to the right. (R. 183) Dr. Durward noted Anderson's neck films were "normal other than some straightening of the cervical lordosis"; her low back films demonstrated "a grade II spondylolysis and spondylolisthesis"; and the MRI of her neck showed "some mild cervical spondylosis with mild narrowing of the cervical canal, particularly C5-6 and C607. No cord or root compression, however." (R. 180) The doctor opined Anderson's neck and arm complaints were "purely inflammatory in nature," and he stated her "low back pain is probably related to the spondylolysis and spondylolisthesis." (*Id.*) He found no explanation for Anderson's transient paralysis in her limbs, or the numbing and tingling she reported. He referred Anderson to Dr. Nitz for a neurological consultation, and he prescribed a back brace and low back exercises. (*Id.*)

Anderson saw Dr. Nitz on July 7, 1993, for a neurologic consultation regarding her upper extremity paresthesias and pain. (R. 173-77) Her neurologic examination was unremarkable "except for mild diffuse hyperreflexia." (R. 173) Dr. Nitz opined that Anderson's symptoms were "functional in nature," noting she had some history of depression, and a somewhat flat affect. (*Id.*) The doctor stated, "I do not feel that her symptoms are correlated with the findings on MRI scan [of] cervical spine." (*Id.*) He ordered evoked potential studies and an MMPI test. Dr. Nitz later advised Anderson that her studies "showed normal evoked potential." (R. 166) He opined Anderson's symptoms could be related to her difficulty in handling day-to-day stresses. Dr. Nitz suggested Anderson seek counseling from a psychologist or psychiatrist, and change her medications. (*Id.*)

Anderson saw Dr. Durward on September 1, 1993, for a follow-up examination after her psychological and neurological evaluations. The doctor noted Anderson's back pain had largely resolved with the back brace and exercises. Anderson was still getting

some occasional discomfort in her left leg, but the doctor noted she was "fully functional without need of analgesics." (R. 179) Dr. Durward recommended conservative treatment for Anderson's spondylolisthesis, and suggested she might want to consider surgery later if her lumbar radiculopathy worsened. (*Id.*)

The Record contains no further evidence of Anderson's back problems between September 1, 1993, and March 26, 1997,[4] when she had an MRI of her lumbar spine. The MRI indicated (1) "Bilateral spondylolysis at L5 with Grade II anterolisthesis of L5 on S1 with marked narrowing of the L5-S1 disc space"; (2) "Marked narrowing of both L5-S1 neuroforamina with probable impingement of both L5 nerve roots"; and (3) "Mild to moderate diffuse posterior disc bulge at L4-5 which is of no clinical significance neurologically." (R. 216) Incidental findings included small hemangiomas within the body of T11, in L3 and L5, and in the body of L4. (*Id.*)

On March 31, 1997, Anderson underwent an MRI of her cervical spine. The MRI showed "a small posterior and central disc protrusion at C5-6," with "moderate central stenosis at that level with indentation on the anterior aspect of the spinal cord." (R. 215) The MRI also showed a posterior disc herniation at C6-7 with facet hypertrophy, "causing severe central stenosis and deformity of the anterior aspect of the spinal cord." (*Id.*)

On April 29, 1997, Anderson saw Leonel Herrera, M.D. for pain in her neck, shoulders, lower back, both hips, both legs, and upper back; numbness in her hands; and

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[4]There is one medical record during this period indicating that on October 10, 1995, Anderson went to the medical center complaining of left wrist pain. Doctor's notes indicate Anderson "was lifting certain things with her left wrist and suddenly developed pain, which seems to be localized over the radial aspect of the wrist. She has difficulty turning or moving her wrist joint." (R. 195) Anderson was diagnosed with tendinitis of her left wrist. She was advised to use a wrist splint and heat pack, and to avoid lifting more than 10 pounds. The doctor prescribed Voltarin and Darvocet-N. (*Id.*)

headaches. (R. 210-13) Anderson reported her pain symptoms are chronic, and have been present since at least 1991. She stated she falls frequently. Anderson rated her neck and upper back pain at 8 out of 10, "severe causing significant disability." (R. 210) She rated her shoulder pain at 8 out of 10; her arm pain at 6 out of 10, "moderate and tolerable requiring restrictions of daily activities" (*id.*); her lower back pain at 9 out of 10; and her leg pain at 7 out of 10. She reported having daily pain, which worsens with activity. She complained of numbness and tingling in both hands, and stated her left hand and wrist are weak. She also reported headaches three or four days each week. (*Id.*)

Anderson stated her pain sometimes wakes her up at night, and changing positions sometimes helps relieve the pain. She reported numbness in her toes, and stated "her hips will give out on her." (R. 211) She also described tingling in her feet, and stated she can only walk four to five blocks at a time and "must take it slow and easy." (*Id.*) She also reported pain in the tip of her tailbone, causing her whole leg to become painful and "give[] way." (*Id.*) Anderson stated her back pain worsens with standing, walking, lifting, housework, coughing, and sneezing. The pain is reduced by sitting, lying down, arising from a chair slowly, bed rest, physical therapy, chiropractic manipulation, heat, braces, and pain medications. She stated her neck pain worsens with standing, walking, lifting, arising from a chair, and housework, and is reduced by sitting and lying down. (*Id.*)

Dr. Herrera performed SI joint injections on Anderson, and reviewed the MRI and X-ray studies. He diagnosed Anderson with (1) "Right sacroiliac chronic ligamentous sprain - improved with SI joint injection"; (2) "Bilateral L5 radiculopathies as per MRI"; (3) "Cervical spinal stenosis with long tract signs of hyperreflexia noted in lower extremities"; (4) "Chronic wrist ligamentous sprains with chronic weakness in the wrists"; (5) "Depression"; (6) "Asthma"; (7) "Multiple allergies"; (8) "Hyperlipidemia."

(R. 213) He made the following recommendations: (1) "Right S1 joint injection"; (2) Bilateral upper extremity EMG"; (3) "I will follow-up with this patient after above studies and treatment"; (4) "Once back pain is stabilized, will focus on treatment for the cervical spine. May need bilateral L5 nerve root block and/or an epidural flood to help with the leg pain"; (5) "Cervical MRI's were not available and I will need to take a look at these as this patient may certainly need a cervical decompression and fusion." (*Id.*)

At a follow-up exam on May 20, 1997, Anderson reported her low back pain was "much improved" after the SI joint injections. Where her pain had been rated at 9 out of 10, now it was 1-2 out of 10. Her leg pain persisted at 7 out of 10, and the other areas of pain were unchanged. The doctor recommended an epidural flood at L5-S1, which he administered to Anderson on June 9, 1997. (*Id.*) When Anderson returned for follow-up exam on June 24, 1997, she reported she felt improvement overall following the epidural flood. The doctor noted:

> She is now walking 10 blocks and normally only is able to walk 8. Her leg pain is down to a 5 out of 10 and the numbness is now more on the right [than] the left. Patient has also had good response to right sacroiliac joint injection and reports her low back pain is also much improved and has remained so. Had been receiving physical therapy and doing well with this. . . . I have advised this patient that I believe she is a surgical candidate[;] however she at this time does not want to consider surgery."

(R. 209) Dr. Herrera made the following recommendations to Anderson:

1. Stop routine physical therapy and patient to be instructed in home exercise program for the cervical spine and lumbar spine.
2. Patient should be seen twice in physical therapy for the home exercise program.

3. Would recommend surgical decompression for the cervical spinal stenosis and fusion of the Grade 3 spondylolisthesis when patient is ready for surgery.
4. Continue with home exercise program as directed.
5. Follow-up will be on an as needed basis.
6. I advised the patient that I would be most happy to refer her to Dr. Samuelson for consideration of fusion of the lumbar spine and/or a cervical diskectomy and fusion.

(*Id.*)

The Record contains no further evidence of treatment for Anderson's pain complaints.

***c. Depression***

There is no evidence Anderson ever received any treatment from a psychologist or psychiatrist for depression. Her family doctor prescribed Zoloft in 1992, and soon thereafter switched the medication to Amitriptyline. (R. 207)

As noted previously, when Dr. Nitz performed a neurological exam of Anderson in July 1993, he noted Anderson had some history of depression and a somewhat flat affect. He concluded Anderson's symptoms could be related to her difficulty handling day-to-day stresses, and he referred her for some testing. Anderson underwent a psychological evaluation by James A. Fish, Ph.D. on August 2, 1993. (R. 167-72) Dr. Fish noted Anderson was "quite destitute" financially. She described herself as moderately depressed, and she had quite low self esteem. He observed that she was "significantly self-dissatisfied and lacking in skills which might improve her conditions. She would tend to see herself as having difficulty in coping with even day to day stressors." (R. 167) Anderson's MMPI test results indicated "a rather shy, introverted individual who is rather passive and ineffective in the expression of her needs and

emotions. The pattern represents a mixed neurotic trend with depression and somatization predominating." (R. 167-68) Dr. Fish stated treatment with medications could be beneficial to Anderson. (R. 168)

Anderson apparently began taking Paxil at some point, because records from the Ohme Medical Center show a refill of Paxil on July 5, 1994. (*Id.*)

Anderson underwent a mental status examination by Michael P. Baker, Ph.D. on October 11, 2000, incident to an application for disability benefits. She reported she was "trying again for disability based on my back and neck." (R. 217) Anderson reported "considerable pain when she walks, bends, moves." She stated the pain injections she received in 1997, "helped only for a matter of days," and although she was told surgery was a possibility, "it could make things worse." (*Id.*) "She stated that spinal bifida was present at birth." (*Id.*)

Dr. Baker noted the following from his mental status exam of Anderson:

> [Anderson] lives next door to her companion named Jim, who assists her financially in getting medications apparently. She feels that she assists him in raising his youngest daughter. . . . She has never been hospitalized for psychiatric reasons. She's never had drug or alcohol treatment. There is a family history of drinking problems. Presently, she is on Celexa, she stated, for anxiety and "years before I was on medication for depression." The last time was on Paxil about five years ago.
>
> Recently, [Anderson] feels that she is not so depressed, but that she is anxious. Her one son joined the military a couple of years ago and she's had a difficult time adjusting to that. It was at this time that she was placed on Celexa. She reports very poor sleep. Her daily activities include arising fairly early to watch a grandson. However, if she is not watching this young person, she may get up anywhere between eight and eleven a.m. She reports no significant change in appetite

> recently with no weight change. She does her own cooking and she shops "when Jim gets paid." She has been responsible for paying her own bills in the past.
>
> While [Anderson] reports feeling "anxious and worried about everything," she denies panic attacks on a regular basis, though admits to having some occur "a long time ago." She denies ever having had suicidal ideation. She admits to numerous crying spells, usually "by myself." She reports poor memory. She was able to recall three things after a number of minutes of interview. Concentration also was complained about, but she added, "maybe it's just that I'm not paying attention."
>
> [Anderson's] complaints were rather vague at times. She is on medication for anxiety as well as three medications for pain, asthma, and allergies. There was no detection of delusional thinking, nor was there looseness of association present in her thinking. She seemed able to remain focused on the discussion. By her own report, a generalized anxiety disorder may be appropriate. Affect was appropriate. Intellectual level would appear to be in the low average range. Memory is intact.
>
> Mental limitations might affect her concentration level and attention in maintenance due to the anxiety. She was able to interact appropriately with this evaluator. She's not had a great deal of outside work experience. Ability to remember and understand instructions would not seem limited.

(R. 217-28)

Dr. Baker diagnosed Anderson with "generalized anxiety disorder versus dysthymic disorder," and gave her a current GAF of 70, indicating "mild symptoms or some difficulty with social and occupational functioning." (*See* DSM-IV at 32)

On November 7, 2000, Anderson saw J.S. Burgfechtel, M.D. for a physical examination, also in connection with her disability application. (R. 219-23) Anderson

provided a history of her physical complaints, and the doctor noted she was "a fair historian." Anderson told the doctor "she believes she can carry light groceries or perhaps a gallon of milk, but even that may be difficult. She is able to walk 4-6 blocks and sit 1/2-1 hour. She does her own bed and some vacuuming but that is about all the housework she feels capable of." (R. 219)

Dr. Burgfechtel summarized his physical findings as follows:

> [Anderson] appeared to have normal range of motion of her upper extremities, normal grip strength and reflexes in her upper extremities. Sensation and reflexes seem normal. She did have mild grading but normal range of motion in both shoulders. She did have some sensitivity in both lower paracervical muscles and left and right trapezius. Pulses in her feet were palpable. No real atrophic changes or deformities. She did have decreased sensation in her right foot to pinch and light touch as compared to the left, however. Reflexes still seem intact. Knee, hip and ankle range of motion seemed within normal limits. Pelvis had a slight leftward tilt. Some suspicion of a left lumbar or right dorsal curvature relatively mild. She was uncomfortable on palpation in the mid and lower lumbar spine, SI joints and right sciatic notch. Straight leg raising was moderately painful at approximately 60-70" on the right, slightly so at 80-90" on the left. Squat, walking on heels and toes was accomplished though with mild to moderate difficulty. Same with getting on her hands and knees and returning to standing. Romberg was negative.

(R. 220)

Based on these findings, the doctor assessed Anderson as having (1) "Long-standing cervical and lumbar pain, presently no definite evidence for radiculopathy from the neck"; (2) "Probable long-standing right sciatica with possible mild to moderate

scoliosis/ spondylosis"; (3) "Chronic moderate asthma"; and (4) "Recurrent anxiety." (*Id.*) He concluded the following with respect to Anderson's work limitations:

> Lifting and carrying would appear to be pretty much as described with light weight. Standing, moving about, walking and sitting are accomplished but are mildly to moderately symptomatic after 30-60 minutes. Stooping, climbing, kneeling and crawling would appear to be poorly tolerated. Handling objects, seeing, hearing, speaking and traveling do not seem obviously impaired. Work environment would be one free of dust, fumes and extremes in temperature regarding her asthma. She did not appear to have any significant extremity joint disease of significance.

(*Id.*)

On February 12, 2001, Dee E. Wright, Ph.D. performed a Psychiatric Review Technique (R. 141-55) and found Anderson was not disabled due to any mental problem from September 1, 2000, through February 12, 2001.[5] (R. 153) Although Dr. Wright recognized Anderson had been diagnosed "with a medically determinable mental impairment - a generalized anxiety disorder (mild)," he concluded the impairment "does not appear to create significant restrictions of function for [Anderson] cognitively, socially, or with activities of daily living from a psychological perspective." (*Id.*) Dr. Wright found Anderson's allegation of disability to be credible "to the extent that she does have a diagnosed medically determinable mental impairment which is considered non severe at this time." (*Id.*) John C. Garfield, Ph.D. reviewed the record and Dr. Wright's Psychiatric Review Technique, and concurred with Dr. Wright's conclusions. (R. 141)

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[5]Dr. Wright cites Anderson's alleged disability onset date as September 1, 2000, and his assessment was only for the period from that date to February 12, 2001. The court is unable to determine the source of Dr. Wright's information regarding Anderson's alleged disability onset date. The documentation of record and the ALJ's opinion cite to an alleged onset date of May 1, 1991. (*See* R. 11, 99)

On May 19, 2001, Dennis A. Weis, M.D. performed a Physical Residual Functional Capacity Assessment of Anderson. (R. 156-65) Dr. Weis concluded Anderson can lift 20 pounds occasionally and 10 pounds frequently, and she can stand, walk, and sit, with normal breaks, for about six hours in an eight-hour workday. He found Anderson to have no other limitations. Dr. Weis noted "a number of inconsistencies which erode [Anderson's] credibility," in particular a three-year gap since she last obtained or sought medical treatment. (R. 164) He found his conclusions to be consistent with those reached by Dr. Burgfechtel in his consultative examination. (*Id.*)

### *4. Vocational expert's testimony*

The VE testified he had never seen or counseled Anderson, and he had not talked with the ALJ prior to the hearing about the merits of Anderson's claim. (R. 68) The ALJ posed the following hypothetical question to the VE:

> [A]ssume that I find that an individual that has worked in the past but not within – that would meet the test of past relevant work for Social Security purposes, it's got – to do that, it's got to be long enough to learn how to do it, it's got to be in the last 15 years, and it has to be at the substantial gainful activity level. So I want you to assume that a person that is high school educated in a regular educational setting, an individual that is 50 years of age or more, but not yet 55, for milestone birthdays. I want you to assume a person that has medically determinable impairments that cause the same work-related limitations described by Ms. Anderson in her testimony, both exertionally and non-exertionally. Crediting that testimony, would you expect the person to be able to work on a full-time basis?

(R. 69) The ALJ replied that the hypothetical individual would not be able to work on a full-time basis, noting Anderson "reports difficulties with her hands, problems sitting for

any sustained period of time, standing for any sustained period of time and walking only very short distances. She also describes chronic pain conditions variously throughout her body." (*Id.*)

The ALJ then posed a second hypothetical, as follows:

> Again, the person is 50 years of age or more, high school educated, no work history. Assume with me a person that could occasionally lift or carry 20 pounds, frequently 10 pounds, could stand and/or walk and/or sit with normal breaks about six hours of eight. Push/pull activities would be unlimited, postural limits are occasional in all categories. No manipulative, visual, communicative, or environmental limits. This would suppose light work, would it not?

(R. 69-70) The VE replied, "Yes, it would." (R. 70) The VE noted there would be a reduction in the full range of light work consistent with the postural limitations cited in the hypothetical, but he opined "50 percent or half of the jobs would still be available under this hypothetical." (*Id.*) Examples of jobs he thought the hypothetical individual would be able to perform include small products assembler, folder in a laundry, or cashier II, all of which exist in sufficient numbers both in Iowa and nationally. (*Id.*) The VE testified the hypothetical claimant's lack of past relevant work would have no bearing on his answer, noting that someone who has not worked outside the home could learn the types of jobs the VE had cited. (R. 72-73)

The ALJ posed a third hypothetical to the VE, considering an individual who could carry less than 10 pounds; whose symptoms would increase after standing, walking, or sitting for 30 to 60 minutes; who has poor tolerance for stooping, climbing, kneeling and crawling; who has no limitations on handling, seeing, hearing, speaking, and traveling; and who requires a work environment free of dust, fumes, and temperature extremes. (R. 70-71) The VE responded that with these limitations, the individual would move into

"the sedentary classification," would be precluded from performing all jobs in the light classification, and would be disabled by operation of law. (R. 71)

### *5. The ALJ's conclusion*

On January 28, 2002, the ALJ issued an opinion denying Anderson's application for benefits. The ALJ found Anderson had not engaged in substantial gainful activity since her alleged disability onset date of May 1, 1991, and she had no past relevant work. (R. 22, ¶¶ 1 & 7) He noted she has a high school education, and is "an individual closely appointing advanced age." (*Id.*, ¶¶ 8 & 9)

The ALJ acknowledged Anderson's history of asthma and allergies, but he noted she had not obtained regular medical treatment for those problems since 1995, and the medical consultants found her "history of reactive airway disease [to be] stable on an outpatient basis with hand held nebulizers[.]" (R. 13) The ALJ adopted the medical consultants' conclusion that Anderson's asthma was not severe, and found those findings to be inconsistent with Anderson's subjective complaints. He concluded that any impairment based on Anderson's asthma or allergies "no more than minimally impacts on [her] ability to perform work-related activities." (*Id.*)

The ALJ also relied on the medical consultant's assessment in finding Anderson's anxiety disorder "does not create significant restrictions of function cognitively, socially, or with activities of daily living from a psychological perspective and . . . is not severe." (*Id.*) He noted Anderson had never been treated by a psychiatrist or psychologist, and her last treatment for mental health problems was seven years prior to the hearing. Although Anderson "described poor memory and poor concentration," the Record failed to substantiate her claimed limitations resulting from psychological disturbances. (R. 13-14)

On the other hand, the ALJ found Anderson to have a severe impairment consisting of the following:

> [B]ilateral spondylolysis[6] at L5 with anterolisthesis[7] of L5 on S1 with marked narrowing of the L5-S1 disc space, marked narrowing of both L5-S1 neuroforamina with possible impingement of both L5 nerve roots, and mild to moderate disc bulge at L4-5; as well as posterior right paracentral and central disc herniation at C6-7 along with facet hypertrophy causing severe central stenosis and deformity of the anterior aspect of the spinal cord, and posterior disc protrusion at C5-6 causing moderate central stenosis and mild indentation on the anterior aspect of the spinal canal[.]

(R. 14; 22, ¶ 2) However, he concluded Anderson's "medically determinable impairment does not meet or medically equal one of the listed impairments in [the Regulations]." (*Id.*, ¶ 3) He therefore undertook a detailed analysis pursuant to *Polaski v. Heckler*, 739 F.2d 1320 (8th Cir. 1984). (*See* R. 14-19)

Based on his analysis, the ALJ found Anderson's subjective complaints to be inconsistent with and not supported by the evidence of record. (R. 15-18) He noted Anderson's "description as to the level, severity, and frequency of her pain, and limitations resulting from such pain [were] inconsistent with her lack of medical treatment, her unrestricted daily activities that include[d] caring for her granddaughter, and objective medical findings that [did] not support subjective complaints." (R. 22, ¶ 4) Although he found Mr. Farrell's testimony to be "sincere and genuine," the ALJ noted the witness's testimony, standing alone, was not a basis for a finding of disability. (*Id.*)

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[6] "Spondylolysis" is defined as "the breaking down of a vertebra." *Dorland's Pocket Medical Dictionary*, 635 (23rd ed. 1982).

[7] "In anterolisthesis, the upper vertebral body is positioned abnormally compared to the lower vertebral body. More specifically, the upper vertebral body slips forward upon the one below it." www.medfriendly.com (08/12/03).

The ALJ accepted the determinations of the medical consultants in defining Anderson's limitations (*id.*, ¶ 5), and found Anderson to have the following abilities:

> The claimant is capable of capacity: sitting, standing, walking up to 6 hours in an 8-hour workday with normal breaks; lifting/carrying 10 pounds frequently and 20 pounds occasionally; and occasionally climbing, balancing, stooping, kneeling, crouching, and crawling. There is no medical documentation of additional mental, postural, manipulative, visual, communicative, or environmental limitations.

(*Id.*, ¶ 6; *see* R. 20-21) Although the ALJ noted Anderson is not able to perform the full range of light work (*see* R. 21, 22 ¶ 10), he found she "has the residual functional capacity to perform a significant range of light work," including such jobs as small parts assembler, laundry folder, and cashier II. (R. 22-23, ¶¶ 10 & 11) The ALJ concluded Anderson "was not under a 'disability,' as defined in the Social Security Act, at any time through the date of [the] decision." (R. 23, ¶ 12)

## *III. DISABILITY DETERMINATIONS, THE BURDEN OF PROOF, AND THE SUBSTANTIAL EVIDENCE STANDARD*

### *A. Disability Determinations and the Burden of Proof*

Section 423(d) of the Social Security Act defines a disability as the "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 423(d)(1)(A); 20 C.F.R. § 404.1505. A claimant has a disability when the claimant is "not only unable to do his previous work but cannot, considering his age, education and work experience, engage in any other kind of substantial gainful work

which exists . . . in significant numbers either in the region where such individual lives or in several regions of the country." 42 U.S.C. § 432(d)(2)(A).

To determine whether a claimant has a disability within the meaning of the Social Security Act, the Commissioner follows a five-step process outlined in the regulations. 20 C.F.R. §§ 404.1520 & 416.920; *see Kelley v. Callahan*, 133 F.3d 583, 587-88 (8th Cir. 1998) (citing *Ingram v. Chater*, 107 F.3d 598, 600 (8th Cir. 1997)). First, the Commissioner must determine whether the claimant is currently engaged in substantial gainful activity. Second, he looks to see whether the claimant labors under a severe impairment; *i.e.*, "one that significantly limits the claimant's physical or mental ability to perform basic work activities." *Kelley*, 133 F.3d at 587-88. Third, if the claimant does have such an impairment, then the Commissioner must decide whether this impairment meets or equals one of the presumptively disabling impairments listed in the regulations. If the impairment does qualify as a presumptively disabling one, then the claimant is considered disabled, regardless of age, education, or work experience. Fourth, the Commissioner must examine whether the claimant retains the residual functional capacity to perform past relevant work.

Finally, if the claimant demonstrates the inability to perform past relevant work, then the burden shifts to the Commissioner to prove there are other jobs in the national economy that the claimant can perform, given the claimant's impairments and vocational factors such as age, education and work experience. *Id.*; *accord Pearsall v. Massanari*, 274 F.3d 1211, 1217 (8th Cir. 2001) ("[I]f the claimant cannot perform the past work, the burden then shifts to the Commissioner to prove that there are other jobs in the national economy that the claimant can perform.") (citing *Cox v. Apfel*, 160 F.3d 1203, 1206 (8th Cir. 1998)).

Step five requires that the Commissioner bear the burden on two particular matters:

> In our circuit it is well settled law that once a claimant demonstrates that he or she is unable to do past relevant work, the burden of proof shifts to the Commissioner to prove, first that the claimant retains the residual functional capacity to do other kinds of work, and, second that other work exists in substantial numbers in the national economy that the claimant is able to do. *McCoy v. Schweiker*, 683 F.2d 1138, 1146-47 (8th Cir. 1982) (*en banc*); *O'Leary v. Schweiker*, 710 F.2d 1334, 1338 (8th Cir. 1983).

*Nevland v. Apfel*, 204 F.3d 853, 857 (8th Cir. 2000) (emphasis added); *accord Weiler v. Apfel*, 179 F.3d 1107, 1110 (8th Cir. 1999) (analyzing the fifth-step determination in terms of (1) whether there was sufficient medical evidence to support the ALJ's residual functional capacity determination and (2) whether there was sufficient evidence to support the ALJ's conclusion that there were a significant number of jobs in the economy that the claimant could perform with that residual functional capacity); *Fenton v. Apfel*, 149 F.3d 907, 910 (8th Cir. 1998) (describing "the Secretary's two-fold burden" at step five to be, first, to prove the claimant has the residual functional capacity to do other kinds of work, and second, to demonstrate that jobs are available in the national economy that are realistically suited to the claimant's qualifications and capabilities).

### *B. The Substantial Evidence Standard*

Governing precedent in the Eighth Circuit requires this court to affirm the ALJ's findings if they are supported by substantial evidence in the record as a whole. *Krogmeier v. Barnhart*, 294 F.3d 1019, 1022 (8th Cir. 2002) (citing *Prosch v. Apfel*, 201 F.3d 1010, 1012 (8th Cir. 2000)); *Weiler, supra*, 179 F.3d at 1109 (citing *Pierce v. Apfel*, 173 F.3d 704, 706 (8th Cir. 1999)); *Kelley, supra*, 133 F.3d at 587 (citing *Matthews v. Bowen*, 879 F.2d 422, 423-24 (8th Cir. 1989)); 42 U.S.C. § 405(g) ("The findings of the Commissioner of Social Security as to any fact, if supported by substantial evidence, shall

be conclusive. . . ."). Under this standard, "[s]ubstantial evidence is less than a preponderance but is enough that a reasonable mind would find it adequate to support the Commissioner's conclusion." *Krogmeier*, *id.*; *Weiler*, *id.*; *accord Gowell v. Apfel*, 242 F.3d 793, 796 (8th Cir. 2001) (citing *Craig v. Apfel*, 212 F.3d 433, 436 (8th Cir. 2000)); *Hutton v. Apfel*, 175 F.3d 651, 654 (8th Cir. 1999); *Woolf v. Shalala*, 3 F.3d 1210, 1213 (8th Cir. 1993).

Moreover, substantial evidence "on the record as a whole" requires consideration of the record in its entirety, taking into account both "evidence that detracts from the Commissioner's decision as well as evidence that supports it." *Krogmeier*, 294 F.3d at 1022 (citing *Craig*, 212 F.3d at 436); *Willcuts v. Apfel*, 143 F.3d 1134, 1136 (8th Cir. 1998) (quoting *Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 488, 71 S. Ct. 456, 464, 95 L. Ed. 456 (1951)); *Gowell, id.; Hutton*, 175 F.3d at 654 (citing *Woolf*, 3 F.3d at 1213); *Kelley*, 133 F.3d at 587 (citing *Cline v. Sullivan*, 939 F.2d 560, 564 (8th Cir. 1991)).

In evaluating the evidence in an appeal of a denial of benefits, the court must apply a balancing test to assess any contradictory evidence. *Sobania v. Secretary of Health & Human Serv.*, 879 F.2d 441, 444 (8th Cir. 1989) (citing *Steadman v. S.E.C.*, 450 U.S. 91, 99, 101 S. Ct. 999, 1006, 67 L. Ed. 2d 69 (1981)). The court, however, does "not reweigh the evidence or review the factual record *de novo*." *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996) (quoting *Naber v. Shalala*, 22 F.3d 186, 188 (8th Cir. 1994)). Instead, if, after reviewing the evidence, the court finds it "possible to draw two inconsistent positions from the evidence and one of those positions represents the agency's findings, [the court] must affirm the [Commissioner's] decision." *Id.* (quoting *Robinson v. Sullivan*, 956 F.2d 836, 838 (8th Cir. 1992), and citing *Cruse v. Bowen*, 867 F.2d 1183, 1184 (8th Cir. 1989)); *see Hall v. Chater*, 109 F.3d 1255, 1258 (8th Cir.

1997) (citing *Roe v. Chater*, 92 F.3d 672, 675 (8th Cir. 1996)). This is true even in cases where the court "might have weighed the evidence differently." *Culbertson v. Shalala*, 30 F.3d 934, 939 (8th Cir. 1994) (citing *Browning v. Sullivan*, 958 F.2d 817, 822 (8th Cir. 1992)); *accord Krogmeier*, 294 F.3d at 1022 (citing *Woolf*, 3 F.3d at 1213). The court may not reverse "the Commissioner's decision merely because of the existence of substantial evidence supporting a different outcome." *Spradling v. Chater*, 126 F.3d 1072, 1074 (8th Cir. 1997); *accord Pearsall*, 274 F.3d at 1217; *Gowell*, *supra*.

On the issue of an ALJ's determination that a claimant's subjective complaints lack credibility, the Sixth and Seventh Circuits have held an ALJ's credibility determinations are entitled to considerable weight. *See, e.g., Young v. Secretary of H.H.S.*, 957 F.2d 386, 392 (7th Cir. 1992) (citing *Cheshier v. Bowen*, 831 F.2d 687, 690 (7th Cir. 1987)); *Gooch v. Secretary of H.H.S.*, 833 F.2d 589, 592 (6th Cir. 1987), *cert. denied*, 484 U.S. 1075, 108 S. Ct. 1050, 98 L. Ed. 2d. 1012 (1988); *Hardaway v. Secretary of H.H.S.*, 823 F.2d 922, 928 (6th Cir. 1987). Nonetheless, in the Eighth Circuit, an ALJ may not discredit a claimant's subjective allegations of pain, discomfort or other disabling limitations simply because there is a lack of objective evidence; instead, the ALJ may only discredit subjective complaints if they are inconsistent with the record as a whole. *See Hinchey v. Shalala*, 29 F.3d 428, 432 (8th Cir. 1994); *see also Bishop v. Sullivan*, 900 F.2d 1259, 1262 (8th Cir. 1990) (citing *Polaski v. Heckler*, 739 F.2d 1320, 1322 (8th Cir. 1984)). As the court explained in *Polaski v. Heckler:*

> The adjudicator must give full consideration to all of the evidence presented relating to subjective complaints, including the claimant's prior work record, and observations by third parties and treating and examining physicians relating to such matters as:
>
> 1) the claimant's daily activities;

2) the duration, frequency and intensity of the pain;
3) precipitating and aggravating factors;
4) dosage, effectiveness and side effects of medication;
5) functional restrictions.

*Polaski*, 739 F.2d 1320, 1322 (8th Cir. 1984). *Accord Ramirez v. Barnhart*, 292 F.3d 576, 580-81 (8th Cir. 2002).

## *IV. ANALYSIS*

Anderson argues the ALJ improperly discounted the opinions of Drs. Burgfechtel and Herrera, and erred in finding she retains the capacity for light work. (*See* Doc. No. 10, pp. 5-8) Anderson notes Dr. Burgfechtel found her medical history to be compatible with her symptoms and subjective complaints, and the doctor "accepted her complaints as credible." (Doc. No. 10, p. 6) The limitations Dr. Burgfechtel found Anderson to have were included in the third hypothetical question the ALJ posed to the VE (*see* R. 70-71), and Anderson points out that based on that hypothetical, both the ALJ and the VE concluded the individual described would be limited to sedentary work and would be disabled by operation of law. Therefore, Anderson argues the ALJ erred in finding she retains the capacity for light work. (*Id.*)

Contrary to Anderson's assertion, the ALJ's opinion is not silent regarding the impact of Dr. Burgfechtel's assessment. The ALJ first considered the report of Dr. Rex Jones, a chiropractor who examined in Anderson in 1995. Dr. Jones found Anderson could carry no more than 20 pounds occasionally and 5 pounds repeatedly, and she could not walk for any extended distance. The ALJ found Dr. Jones's assessment to be outdated. Then the ALJ found that, with one exception related to environmental

limitations, Dr. Burgfechtel's assessment was a more accurate definition of Anderson's work-related limitations than Dr. Jones's opinion. The ALJ noted:

> The physician who performed a consultative examination on October 31, 2000 [*i.e.*, Dr. Burgfechtel], stated lifting and carrying appeared to be with light weight; standing, moving about, walking and sitting were accomplished but are mildly to moderately symptomatic after 30 to 60 minutes; stooping, kneeling, climbing, and crawling would appear poorly tolerated; handling objects did not seem obviously impaired; and the work environment should be one free of dust, fumes, and extremes of temperature with regard to the claimant's asthma. [Citation omitted.] The undersigned finds such assessment more accurately defines the claimant's work-related limitations, other than there is no medical basis for limiting the claimant from an environmental standpoint as discussed earlier in this decision.

(R. 19; *see* R. 219-23) Taking this finding in context, the ALJ clearly placed more weight on Dr. Burgfechtel's assessment of Anderson's limitations than on Dr. Jones's assessment. However, the ALJ then considered Dr. Weis's opinion, and found he more accurately described Anderson's limitations than did Dr. Burgfechtel.

Dennis A. Weis, M.D. is a medical consultant who performed a Physical Residual Functional Capacity Assessment of Anderson on May 19, 2001, at the request of the State of Iowa Disability Determination Services. (*See* R. 156-64) Dr. Weis found Anderson retained the capacity to lift/carry up to 20 pounds occasionally and 10 pounds frequently; stand, walk, and sit, with normal breaks, for about six hours in an eight-hour workday; and push/pull without limitation. Dr. Weis found "a number of inconsistencies" in the Record that eroded Anderson's credibility, in particular the fact that there was "[a] greater than three year gap in evidence that she's sought or received medical attention[.]" (R. 164)

The ALJ adopted Dr. Weis's opinion as to Anderson's limitations, noting Dr. Weis's opinion was "consistent with the evidence as a whole" and "well rationalized." (R. 20) When the VE was presented, in the second hypothetical question (*see* R. 69-70), with the limitations specified by Dr. Weis, the VE found the hypothetical claimant would be capable of performing half of the range of light work. (*Id.*) The ALJ chose to accept these conclusions, rather than the opinion of Dr. Burgfechtel and the hypothetical question based on his assessment. Thus, the ALJ did not ignore Dr. Burgfechtel's opinion; rather, he found other evidence to be more persuasive.

Regarding Dr. Herrera's assessment, he last saw Anderson approximately four-and-a-half years prior to the ALJ hearing. At that time, he recommended Anderson consider surgical decompression for her cervical spinal stenosis, and fusion of her Grade 3 spondylolisthesis. (R. 209) However, according to Anderson, he also advised her that surgery likely would not resolve all of her pain complaints, and would leave her with a 15% to 20% restriction. (R. 46, 51) Anderson chose not to take the risks involved with the surgery. In her brief, Anderson argues the ALJ ignored Dr. Herrera's findings, and failed to explain why her condition as diagnosed by Dr. Herrera failed to meet or exceed the criteria in the Listings. (*See* Doc. No. 10, p. 7) She also argues the ALJ failed to recognize "the marked differences" between Anderson's test results in 1993 and 1997, as noted by Dr. Herrera. (*Id.*, p. 8)

The ALJ acknowledged Dr. Herrera's findings (R. 16), but noted that other than Anderson's subjective complaints, the Record is devoid of evidence since 1997 to support Anderson's claim that her disability "has lasted or can be expected to last for a continuous period of not less than twelve months." 42 U.S.C. § 1382c(a)(3)(A). Anderson must show she "was under a continuing disability ***while [her] application was pending***" (emphasis added); that is, from and after September 11, 2002. *Nelson v. Sullivan*, 966

F.2d 363, 364 n.2 (8th Cir. 1992) (citing 42 U.S.C. § 1382(c); 20 C.F.R. §§ 416.330, 416.335).

In determining Anderson failed to show the existence of a continuing disability, the ALJ placed a great deal of weight on the fact that Anderson had failed to obtain medical treatment for several years. It is true that, "[w]hile not dispositive, a failure to seek treatment may indicate the relative seriousness of a medical problem." *Shannon v. Chater*, 54 F.3d 484, 486 (8th Cir. 1995); *accord Tate v. Apfel*, 167 F.3d 1191, 1197 (8th Cir. 1999). A claimant's failure to seek medical treatment may undercut allegations of disabling pain. *See Rankin v. Apfel*, 195 F.3d 427, 429 (8th Cir. 1999) (citing *Harwood v. Apfel*, 186 F.3d 1039, 1045 (8th Cir. 1999); *Black v. Apfel*, 143 F.3d 383, 386-87 (8th Cir. 1998)). However, Anderson claims she did not seek medical treatment because of financial hardship. "Clearly, if the claimant is unable to follow a prescribed regimen of medication and therapy to combat her disabilities because of financial hardship, that hardship may be taken into consideration when determining whether to award benefits. *Tome v. Schweiker*, 724 F.2d 711, 714 (8th Cir. 1984)." *Murphy v. Sullivan*, 953 F.2d 383, 386 (8th Cir. 1992); *but see Tate*, 167 F.3d at 1197 (claimant's failure to seek medical treatment "cannot be wholly excused due to [her] claims of financial hardship") (citing *Murphy*, 953 F.2d at 386-87; *Hutsell v. Sullivan*, 892 F.2d 747, 750 n.2 (8th Cir. 1989) ("lack of means to pay for medical services does not *ipso facto* preclude the Secretary from considering the failure to seek medical attention in credibility determinations.")).

The facts of this case are distinguishable from those in *Murphy*, where there was no evidence the claimant had sought to obtain low-cost medical treatment from doctors or clinics, or was denied medical care due to her financial condition. *See Murphy*, 953 F.2d at 386-87 (citing *Benskin v. Bowen*, 830 F.2d 878, 884 (8th Cir. 1987)). In the

present case, Anderson has continued to see a physician's assistant at the clinic, and has continued to take prescription medications for asthma, allergies, and anxiety, and nonprescription pain relievers. Her resort to less costly medical alternatives on a regular basis is consistent with her subjective complaints and properly should have been considered by the ALJ. *See Benskin v. Bowen*, 830 F.2d 878, 884 (8th Cir. 1987) (affirming denial of benefits where claimant failed to seek medical attention, to use back brace or orthopedic pillows available to her, or to testify "that financial concerns deterred her from seeking less costly medical attention, such as obtaining a prescription for pain medication, or advice on an exercise program, from her doctor over the phone."). The ALJ referred repeatedly to Anderson's failure to seek further medical treatment, yet the ALJ failed to consider whether Anderson's financial hardship was severe enough to justify such failure, a factor the ALJ properly could take into account. *See Murphy*, 953 F.3d at 386-87.

There is no evidence that any treating physician ever disbelieved Anderson's subjective complaints; indeed, Dr. Burgfechtel adopted Anderson's assessment of her lifting ability in his opinion. While it is true Anderson failed to pursue surgery as suggested by Dr. Herrera, her decision to postpone or forego surgery was reasonable under the circumstances, and no other treating physician ever suggested avenues of treatment that Anderson failed to explore. The court therefore finds the ALJ erred in finding Anderson's "allegations regarding her limitations are not totally credible[.]" (R. 22, ¶ 4) When her subjective complaints are taken as credible, under Dr. Burgfechtel's assessment of Anderson's condition, she is disabled as a matter of law.

For these reasons, the court finds the Record does not contain substantial evidence to support the Commissioner's decision. The ALJ should be directed to reconsider

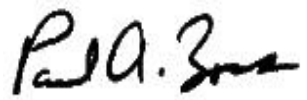
Anderson's application, viewing her subjective complaints of pain and limitation as credible, and therefore giving proper weight to Dr. Burgfechtel's opinion.

## *V. CONCLUSION*

For the reasons discussed above, **IT IS RESPECTFULLY RECOMMENDED**, unless any party files objections[8] to the Report and Recommendation in accordance with 28 U.S.C. § 636 (b)(1)(C) and Fed. R. Civ. P. 72(b), within ten (10) days of the service of a copy of this Report and Recommendation, that judgment be entered in favor of Anderson[9] and against the Commissioner, and that this case be **reversed and remanded** to the Commissioner for further proceedings consistent with this opinion.

**IT IS SO ORDERED.**

**DATED** this 2nd day of September, 2003.



PAUL A. ZOSS
MAGISTRATE JUDGE
UNITED STATES DISTRICT COURT

[8]Objections must specify the parts of the report and recommendation to which objections are made. Objections must specify the parts of the record, including exhibits and transcript lines, which form the basis for such objections. *See* Fed. R. Civ. P. 72. Failure to file timely objections may result in waiver of the right to appeal questions of fact. *See Thomas v. Arn*, 474 U.S. 140, 155, 106 S. Ct. 466, 475, 88 L. Ed. 2d 435 (1985); *Thompson v. Nix*, 897 F.2d 356 (8th Cir. 1990).

[9]If final judgment is entered for the plaintiff, the plaintiff's counsel must comply with the requirements of Local Rule 54.2(b) in connection with any application for attorney fees.

# APPENDIX A

## MEDICAL RECORDS SUMMARY
## *Anderson vs. Barnhart,* Case No. C02-4071-MWB

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| **05/01/91** ***See* R. 99** | **ANDERSON'S CLAIMED DISABILITY ONSET DATE** | | |
| 01/91 R. 207 | Ohme Medical Center | Low back pain | Note in opinion letter that Pt saw Dr. in Jan. 1991, complaining of low back pain. "She had a spondylolithesis of L5/S1. In 1988 it measured 1.5 cm." |
| 08/91 R. 207 | Ohme Medical Center | Low back pain, stiffness | Exam showed "some normal reflexes and some muscle spasm." Refilled Parafon Forte. Prescribed heating pads on neck and low back as needed. |
| 08/92 R. 207 | Ohme Medical Center | Continuing back pain | Pain usually in low back; doesn't radiate down legs, but she has some achiness and pain in her legs when she moves, "esp. if she walks any distance." Assessment: Low back strain. Continue Motrin; Prescribed Zoloft. |
| (sometime after above visit) R. 207 | Ohme Medical Center | Follow-up for back pain | Zoloft didn't work; prescribed Amitriptyline. After this change, Pt's sleeping pattern much better. Repeat X-rays showed spondylolithesis at L5/S1; no problems in cervical neck. Referred for orthopedic evaluation. Pt to continue Amitriptyline, Motrin, Parafon Forte. |
| 09/18/92 R. 178 | Dennis Nitz, M.D. Northwest Iowa Orthopaedics, P.C. | Report from nerve conduction test | "Media nerve conductions are normal bilaterally. No evidence of carpal tunnel syndrome." |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 04/08/93<br>R. 184-85 | Quentin J. Durward, M.D.<br>Sioux City Neurology Neurosurgery, P.C. | Physical exam on referral from Dr. Breeling | Pt complains of diffuse spinal pain, numbness and weakness of upper extremities, and intermittent pain in lower extremities. Physical exam shows "some mild wasting of the hand intrinsics bilaterally but not in a specific pattern." Full ROM of neck on forward flexion/extension, rotation, and lateral flexion; full ROM of back in flexion to 90˚ but extension limited by about 50% by low back pain. Unrestricted straight leg raising; negative foraminal encroachment. "This woman is a bit of a mystery. She has a lot of pain complaints but very little objectively other than this hand intrinsic wasting and that she has a general tendency to hyperreflexia." Ordered MRI, X-rays. Possible formal neurological consult. |
| 06/17/93<br>R. 181 | James C. Beeler, M.D.<br>Marion Health Center | MRI report, cervical spine | Impressions: (1) "Mild bulging annulus C5-6 and C6-7 without focal disc protrusion, cord compression or foraminal encroachment." (2) "Mild reversal of the cervical curvature C3-C5." (3) "Focal bright 3mm. area of increased T1 signal intensity dampened on T2 in the posterior superior C6 vertebral body." |
| 06/17/93<br>R. 182 | Susan Marley Bird, M.D.<br>Marian Health Center | X-ray report | X-rays of lumbar spine showed narrowed disc space at L5-S1, and "approximately 1.5cm. of anterior displacement of L5 upon S1. This is consistent with a Grade II spondylolisthesis. Bilateral pars interarticularis defects are seen at this level. The lumbar spine is otherwise in good alignment. The other disc spaces are of normal height." |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 06/17/93<br>R. 183 | Susan Marley Bird, M.D.<br>Marian Health Center | X-ray report | Impression: "Scoliosis of the cervical spine centered at C4 convex to the right. Otherwise unremarkable." |
| 06/21/93<br>R. 180 | Quentin J. Durward, M.D.<br>Sioux City Neurology Neurosurgery, P.C. | Report from X-rays and MRI | "Basically the films of her neck are normal other than some straightening of the cervical lordosis. Films of her low back demonstrate a grade II spondylolysis and spondylolisthesis. The MRI scan of her neck shows some mild cervical spondylosis with mild narrowing of the cervical canal, particularly C5-6 and C6-7. No cord or root compression, however." Dr. opined Pt's neck and arm complaints were "purely inflammatory in nature," and "low back pain is probably related to the spondylolysis and spondylolisthesis." No explanation for transient paralysis in Pt's limbs, or numbing and tingling. Referred to Dr. Nitz for neurological consultation. Prescribed back brace and low back exercises. Pt referred for orthopedic opinion about spondylolisthesis. Follow up in four weeks. |
| 07/07/93<br>R. 173-77 | Dennis Nitz, M.D.<br>Neurology Associates | Report to referring physician | Dr. saw Pt for neurologic consultation re upper extremity paresthesias and pain. Unremarkable neurologic exam "except for mild diffuse hyperreflexia." No motor or sensory deficits. "I suspect that her symptoms are functional in nature. She does have history of depression and somewhat flat affect. . . . I do not feel that her symptoms are correlated with the findings on MRI scan [of] cervical spine." Ordered evoked potential studies and MMPI test. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 08/02/93<br>R. 167-72 | James A. Fish, Ph.D.<br>Marion Behavioral Health Center | Report from psychological evaluation | Pt complains of pain for last 2 yrs, worse in left arm, but also affects right arm, shoulders, neck, legs, and feet. Pt rated pain at 6-7 on scale of 10. Pain worsens with dampness and chilliness. Pt feels she is moderately depressed. She is financially "quite destitute." MMPI profile is valid, indicating Pt "has a very poor self-concept and is significantly self-dissatisfied and lacking in skills which might improve her conditions. She would tend to see herself as having difficulty in coping with even day to day stressors. The clinical scales indicate a rather shy, introverted individual who is rather passive and ineffective in the expression of her needs and emotions. The pattern represents a mixed neurotic trend with depression and somatization predominating." Psychopharmacology could be beneficial. |
| 08/12/93<br>R. 166 | Dennis Nitz, M.D.<br>Neurology Associates | Opinion letter | Letter to Pt, advising her that studies "showed normal evoked potential." Dr. opined Pt's difficulty handling day-to-day stresses could account for her symptoms. Suggested she seek psychologic or psychiatric consultation and change in medication. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 09/01/93<br>R. 179 | Quentin J. Durward, M.D.<br>Sioux City Neurology Neurosurgery, P.C. | Follow-up exam after evaluation by Dr. Nitz | "Dr. Nitz . . . feels that a lot of [Pt's] symptoms of the neck and arms are conversion and nature. He has recommended no specific treatment for them. Interestingly with doing the exercises for the low back and wearing the brace her back pain has largely resolved. She still gets occasional discomfort in the left leg but is fully functional without need of analgesics." Dr. recommended conservative treatment for Pt's spondylolis-thesis. Possibly consider surgery later, if lumbar radiculopathy worsens. |
| 12/09/93<br>R. 207 | Constance J. Lorenz, D.O.[10]<br>Ohme Medical Center | Opinion letter to Voc-Rehab disability examiner | Dr. has been seeing Pt since January 1991. Details history included in other entries, above. (Second page of Dr.'s letter, containing any opinion, is missing from the Record.) |
| 06/22/94<br>R. 206 | Ohme Medical Center | Allergy shot | Shot given, no reaction. |
| 07/05/94<br>R. 206 | Ohme Medical Center | Medication refill | Refilled Paxil. |
| 07/07/94<br>R. 206 | Ohme Medical Center | Allergy shot | Shot given, no reaction. |
| 07/21/94<br>R. 206 | Ohme Medical Center | Allergy shot | Shot given, no reaction. |
| 08/04/94<br>R. 206 | Ohme Medical Center | Allergy shot | Shot given, no reaction. |

[10]The second page of this opinion letter is missing from the Record, so it is not possible to determine the letter's author. However, Dr. Lorenz is the physician Anderson had been seeing at the Ohme Medical Center, and presumably Dr. Lorenz would have written the letter.

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 08/15/94<br>R. 206 | Constance J. Lorenz, D.O.<br>Ohme Medical Center | Cough, congestion | Pt not feeling well for 2 days. Pharanx is red and swollen w/drainage. Occasional ronchi, esp. on right side. Assessment: Bronchitis. Prescribed Keflex, Phenergan w/Codeine, rest, fluids. Return as needed. |
| 09/21/94<br>R. 205 | Betty Wittrock, P.A.-C.<br>Ohme Medical Center | Nonproductive cough, sinus pressure and drainage, ears "feel full" | Pt has a lot of allergy problems; used to take allergy injections. Pt having trouble breathing. Proventil Repetabs and Seldane B are not helping. Impression: Upper respiratory tract infection, bronchitis with asthmatic component. Prescribed Prednisone, Keflex, Proventil inhaler, plenty of fluids, and let Dr. know how she is doing. |
| 09/28/94<br>R. 205 | Betty Wittrock, P.A.-C.<br>Ohme Medical Center | Follow-up on cough, upper respiratory tract infection | Pt reports coughing more this morning. Pt ran out of Proventil pills 2 days ago, and had not used Proventil inhaler this a.m. Pt coughs on each exhale. Pt was given Susphrine and her symptoms began to improve. Pt was breathing much better, felt better. Pt to finish Prednisone and antibiotics; make sure she has plenty of Proventil pills and doesn't run out. |
| 10/6/94<br>R. 204 | Constance J. Lorenz, D.O.<br>Ohme Medical Center | Nonproductive cough, fatigue | Assessment: continued upper respiratory tract infection, COPD, side effects of Proventil Repetabs. Pt is a smoker. Decreased dose of Proventil Repetabs; prescribed Z-pack, Novahistine DH, rest, fluids. Follow up in 1 wk. |
| 10/12/94<br>R. 204 | Betty Wittrock, P.A.-C.<br>Ohme Medical Center | Follow-up for bronchitis and asthma | Pt is feeling much better and doing well with Proventil inhaler. Finish current meds and let Dr. know how she is doing. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 11/22/94<br>R. 203 | Constance J. Lorenz, D.O.<br>Ohme Medical Center | Head pressure, cough | "Patient is a known case of wheezing and also has a long history of allergic rhinitis." Inflamed throat. Assessment: sinusitis, allergic rhinitis, history of wheezing/bronchitis. Prescribed Cephalexin. Changed from Seldane-D to Entex LA. Return in 2 wks. |
| 12/16/94<br>R. 203 | Ohme Medical Center | Medication refill | Refilled Paxil. |
| 12/20/94<br>R. 203 | Constance J. Lorenz, D.O.<br>Ohme Medical Center | Cough, nasal discharge | History: "Questionable asthma. Frequent episodes of bronchitis." Assessment: Sinusitis; frequent cough, probable etiology bronchitis. Continue current meds; start on Cephalexin. Switch antibiotics in 48-72 hours if no improvement. |
| 01/14/95<br>R. 202 | Constance J. Lorenz, D.O.<br>Ohme Medical Center | Toothache, sore throat, pain in left ear | Pt has infected tooth, upper left, and pharyngitis. Prescribed Amoxicillin, Tylenol #3 w/Codeine |
| 01/19/95<br>R. 202 | Ohme Medical Center | Medication refill | Pt called for refill of Paxil and Entex LA. |
| 02/28/95<br>R. 202 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Cough, right ear pain, head congestion for five days | Assessment: sinusitis, bronchitis. Prescribed Erythromycin. Pt told to humidify her home, increase fluids, use Tylenol for pain. Return as necessary. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 03/29/95 R. 197, 199 | G.A. "Sam" Schwickerath, P.A.C. Ohme Medical Center | Cough, right ear pain, headache | Pt complains of tight, nonproductive cough; right ear discomfort radiating down right side of neck; generalized headache; "feelings of hot and cold," although she denies fever and chills. Pt reports prior history of asthma, treated w/Alupent inhaler and Repetabs. Currently taking Seldane D, Proventil, Paxil. Assessment: Otitis media, sinusitis, bronchial asthma. Peak flow readings of 240, 300, 240. Pt given MaxAir auto inhaler, 2 puffs, and 15 minutes later, wheezing was absent. Pt still felt tightness in chest; given Albuterol updraft treatment; Pt reported definite improvement. Pt given home nebulizer unit w/Albuterol premix; Prednisone burst; MaxAir auto inhaler; Ceclor. Pt to do peak flow readings three times/day; return in 48 hours for follow-up of asthma and meds. Pt given samples of Claritin-D for sinuses. "I stressed the importance of smoking as a definite irritating factor of asthsma [sic] and I also provided her with a list of irritating asthsma [sic] factors." |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 03/31/95<br>R. 200 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow-up of bronchial asthma | Pt reports definite improvement since being placed on Albuterol nebulizer, Ceclor, and Predni-sone burst, but she still has occasional spasmatic cough. Right ear is more uncomfortable than on the 29th. Sinuses are somewhat better since starting Claritin D. Continue current meds; add Seravent and Aerobid inhalers. Pt advised to use Tylenol instead of Ibuprofen, which can aggravate asthma. Return in 3 days for follow-up. |
| 04/02/95<br>R. 197 | Ohme Medical Center | Flow sheet notation | Chart shows peak flow average of 350-390. |
| 04/04/95<br>R. 197-98 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow up of bronchial asthma w/exacerbation | Pt reports definite improvement since beginning drug treatment program, but reports discomfort in ears, especially right ear. Assessment: Resolving bronchial asthma, bilateral otitis externa; early right otitis media. Peak flow reading average 360-390,[11] definite improvement from 3/29 when average was 240-300. Continue current asthma plan & meds (MaxAir auto inhaler, Albuterol updraft, Seravent inhaler, Aerobid inhaler); continue Ceclor, Claritin D. Follow up at end of antibiotic therapy. Gave Pt prescription for peak flow meter and nebulizer unit. |

[11]Note: Flow sheet shows 460-390, rather than 360-390. (*See* R. 197) Given other readings, the 460 appears to be an error.

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 04/19/95<br>R. 197-98 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow up of otitis media, bronchial asthma | Pt states asthma "is doing much, much better and in fact, [she] feels that this is cleared up"; still has discomfort in right ear, tender lymph nodes distal to right ear. Continue Claritin-D, Aerobid inhalers, Seravent inhaler, MaxAir auto inhaler. Prescribed Biaxin. Referred to Dr. Jorgensen for earache. |
| 04/22/95<br>R. 197 | Ohme Medical Center | Medication refill | Refilled Prednisone Burst, Maxair auto inhaler, Albuterol updraft, Claritin D, Biaxin. |
| 08/22/95<br>R. 197 | Ohme Medical Center | Medication refill | Refilled Prednisone Burst, Maxair auto inhaler, Albuterol updraft, Claritin D, Biaxin. Charts notes exacerbation of asthmatic symptoms; peak flow average 320-390. |
| 08/23/95<br>R. 186-87 | Rex J. Jones, D.C.<br>Chiropractic Arts Clinic, P.C. | Opinion letter | Dr. reviewed Pt's X-rays, records from other doctors' examinations, and her subjective complaints. He concluded Pt can lift/carry 20 lbs occasionally and 5 lbs frequently; cannot walk extended distances. Pt "should be an excellent client for some type of vocational or rehabilitation retraining program in which she can do some type of sitting activity." |
| 08/24/95<br>R. 197 | Ohme Medical Center | Flow sheet notations | Chart notes peak flow readings of 370/400, 350/390. |
| 08/29/95<br>R. 197 | Ohme Medical Center | Medication refill | Refilled Seldane, Bromfed; peak flow reading 380/380. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 09/01/95<br>R. 196 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow-up of acute asthma | Acute asthmatic exacerbation is resolving. Pt breathing easier and less coughing. Pt "has been more compliant with her Albuterol updrafts and peak flow readings." Pt reports Bromfed PD helps more than Claritin; continue Bromfed. "Condition good." Continue current plan; stressed importance of Albuterol premix updrafts. Recheck in 1 week. |
| 09/16/95<br>R. 195 | Ohme Medical Center (physician/P.A. unknown) | Ear and jaw pain; toe pain after being poked with a nail | Assessment: Right TMJ syndrome; Cellulitis in left 4th toe. Prescribed Keflex. Gave samples of Voltarin. Pt advised to apply heat to right jaw; eat soft diet; consult with dentist. Pt advised to stop Voltarin if it exacerbates her asthma. |
| 09/21/95<br>R. 195 | Ohme Medical Center (physician/P.A. unknown) | Med refill; flu shot | Refilled Voltarin; administered flu vaccine. |
| 10/10/95<br>R. 195 | Ohme Medical Center (physician/P.A. unknown) | Left wrist pain for 3-4 days | Pt "states that she was lifting certain things with her left wrist and suddenly developed pain, which seems to be localized over the radial aspect of the wrist. She has difficulty turning or moving her wrist joint." Assessment: Tendinitis, left wrist. Pt advised to use wrist splint, heat pack; avoid lifting more than 10 lbs. Prescribed Voltarin, Darvocet-N. Follow up in 1 week. |
| 10/12/95<br>R. 191-94 | J. Labesky, M.D.<br>Spencer Municipal Hospital | Pulmonary Function Report | Pt had pulmonary function study. Results: normal spirometry. |

| DATE | MEDICAL PRACTITIONER/ FACILITY | COMPLAINTS | DIAGNOSIS, TREATMENT & COMMENTS |
|---|---|---|---|
| 10/19/95<br>R. 190 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Allergies and sinuses acting up; facial fullness, throat irritation, ear fullness; tight, non-productive cough | Assessment: bronchitis and sinusitis with underlying allergy component. Pt "came in early this time," so hopefully no URI will develop. Prescribed Z pack, Bromfed PD, Prednisone, Albuterol nebulizer. Pt is on N-said therapy for jaw pain due to dental caries, which Dr. thinks "could definitely be an aggravating cause" of her asthma. Return as needed, unless condition worsens. |
| 10/24/95<br>R. 189 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow-up of bronchitis | Pt back to full activity, doing well, no further episodes of coughing or spasms. Suggested Pt stay on Seravent inhaler, Aerobid inhaler, and Maxair auto inhaler, as well as Bromfed. Follow-up as needed. |
| 12/14/95<br>R. 188 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Sinus congestion, cough, nasal symptoms | Diagnosis: upper respiratory tract infection; chronic sinusitis, probably secondary to allergies. "We'll treat her aggressively as she gets into trouble very rapidly." Prescribed Prednisone; "PCE"; Claritin-D; Albuterol nebulizer. "Also I've reinforced the necessity that as soon as she become[s] symptomatic, she's to start peak/flow readings (as she doesn't do these on a regular basis even though she's been instructed to do so)[.]" Return for follow-up in five days. Consider seeing an allergist "as she really needs to be tested to see if we can get control of these freq[uent] URIs." |
| 12/19/95<br>R. 188 | G.A. "Sam" Schwickerath, P.A.C.<br>Ohme Medical Center | Follow-up of bronchitis and sinusitis | Pt doing well; "verbalizes no requests or concerns." Unremarkable exam; lungs clear. Continue current plan; recheck as needed. |

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| 03/26/97<br>R. 216 | Charles A. Crouch, M.D. | MRI report, lumbar spine | MRI of lumbar spine shows (1) "Bilateral spondylolysis at L5 with Grade II anterolisthesis of L5 on S1 with marked narrowing of the L5-S1 disc space"; (2) "Marked narrowing of both L5-S1 neuroforamina with probable impingement of both L5 nerve roots"; (3) "Mild to moderate diffuse posterior disc bulge at L4-5 which is of no clinical significance neurologically." Incidental findings: small hemangiomas within the body of T11; in L3 and L5; and in the body of L4. |
| 03/31/97<br>R. 215 | Jon Hade, M.D. | MRI report, cervical spine | MRI of cervical spine shows "a small posterior and central disc protrusion at C5-6," with "moderate central stenosis at that level with indentation on the anterior aspect of the spinal cord." Also shows posterior disc herniation at C6-7 w/facet hypertrophy, "causing severe central stenosis and deformity of the anterior aspect of the spinal cord." |
| 04/29/97<br>R. 210-13 | Leonel Herrera, M.D. | Pain in neck, shoulders (left more than right), lower back, both hips, both legs, upper back; numbness in both hands; headaches | Pt referred by "Sam" Schwickerath, P.A.C., for evaluation and treatment. Pt "states symptoms are chronic and have been present at least since 1991." Pt falls frequently. Pt states neck and upper back pain are 8 out of 10, "severe causing significant disability." She states shoulder pain also is 8 out of 10; arm pain is 6 out of 10, "moderate and tolerable requiring restrictions of daily activities"; back pain is 9 out of 10; leg pain is 7 out of 10. "Pain occurs on a daily basis and symptoms are worsened with |

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| | | | activity. Frequency comes and goes and overall it has worsened. Patient reports [she] will have numbness and tingling in both hands and the left hand and wrist are weak. States she will have headaches 3-4 days out of the week." Pain sometimes disturbs sleep; changing positions helps. "Patient reports she will also have numbness in toes and states that her hips will give out on her. Also describes tingling in her feet and states she can only walk about 4-5 blocks and must take it slow and easy. Patient states [she] will have pain in the tip of her tailbone, whole leg becomes painful and gives way and since the onset of her pain has had spells with very little pain." Back pain worsens with standing, walking, lifting, housework, coughing, sneezing. Pain is reduced by sitting, lying down, arising from a chair slowly, bed rest, physical therapy, chiropractic manipulation, heat, braces, pain medication. Neck pain worsens with standing, walking, lifting, arising from chair, housework. Pain is reduced by sitting and lying down.<br><br>Pt describes low back pain as sharp and stabbing; "pain radiating down both lower extremities lateral aspects but according to the patient involving the entire leg with an aching pain in the right anterior groin with no numbness in her feet." Pt complains of pain in upper back, across upper trapezius and posterior shoulder; |

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| | | | pain from lateral epicondyle to thumb both posteriorly and anteriorly w/tingling in all fingers but not thumb.<br><br>Diagnostic studies: "X-rays of the lumbar spine have identified a Grade 3 spondylolisthesis of L5 S1 with spondylolysis and degenerative changes. The X-ray[s] dated 02/24/97 were unchanged from previous studies on 05/31/96. MRI of the cervical spine identifies a posterior right paracentral and central disc herniation at C6-7 with facet hypertrophy causing severe central stenosis and deformity of the anterior aspect of the spinal cord. There is also a posterior disk protrusion at C5-6 causing moderate central canal stenosis and mild indentation into the anterior aspect of the cord. There may also be impingement of the right C7 nerve root and there is noted an hemangioma in the posterior aspect of the superior portion of the C5 vertebral body. The lumbar MRI identified bilateral spondylolysis at L6 with Grade 2 anterolisthesis of L5 on S1 with marked narrowing of the L5 S1 disk space. There is also marked narrowing of the neural foramina bilaterally at L5 S1 with probably impingement of both L5 nerve roots. There is mild to moderate diffuse posterior disk bulge at L4-5 no[t] felt to be producing any symptoms. Some hemangioma also noted in the body of T11 and a mild disk bulge diffuse at L3-4." Impression: (1) "Right |

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| | | | sacroiliac chronic ligamentous sprain - improved with SI joint injection"; (2) Bilateral L5 radiculopathies as per MRI"; (3) "Cervical spinal stenosis with long tract signs of hyperreflexia noted in lower extremities"; (4) "Chronic wrist ligamentous sprains with chronic weakness in the wrists"; (5) "Depression"; (6) "Asthma"; (7) "Multiple allergies"; (8) "Hyperlipide-mia." Recommendations: (1) "Right S1 joint injection"; (2) Bilateral upper extremity EMG"; (3) "I will follow-up with this patient after above studies and treatment"; (4) "Once back pain is stabilized, will focus on treatment for the cervical spine. May need bilateral L5 nerve root block and/or an epidural flood to help with the leg pain"; (5) "Cervical MRI's were not available and I will need to take a look at these as this patient may certainly need a cervical decompression and fusion." |

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| 05/20/97<br>R. 214 | Leonel Herrera, M.D. | Pain in neck, shoulders (left more than right), lower back, both hips, both legs, upper back; numbness in both hands; headaches | "Patient underwent SI joint injections for a right sacroiliac ligamentous sprain which she returns today and reports her low back pain is much improved. It had been a 9 out of 10 and now it is a 1-2 out of 10. Leg pain persists 7 out of 10. The other listed areas of pain are unchanged." Impression: (1) "Right sacroiliac chronic ligamentous sprain - improved with SI joint injection"; (2) Bilateral L5 radiculopathies on MRI"; (3) "Central cervical spinal stenosis with long tract signs of hyperreflexia noted lower extremities"; (4) "Chronic wrist ligamentous sprains with chronic weakness in the wrists"; (5) "Depression"; (6) "Asthma"; (7) "Multiple allergies"; (8) "Hyperlipidemia." Recommended epidural flood at L5-S1; follow-up in 2 weeks. |
| 06/09/97<br>R. 214 | Leonel Herrera, M.D. | Epidural flood | Lumbar Epidural flood performed at L5-S1. |
| 06/24/97<br>R. 209 | Leonel Herrera, M.D. | Pain in neck, shoulders, hips, legs, back; numbness in hands; headache | "Patient states overall she feels improved following the epidural flood. She is now walking 10 blocks and normally only is able to walk 8. Her leg pain is down to a 5 out of 10 and the numbness is now more on the right [than] the left. Patient has also had good response to right sacroiliac joint injection and reports her low back pain is also much improved and has remained so. Had been receiving physical therapy and doing well with this." "I have advised this patient that I believe she is a surgical candidate however she at this time does not want to |

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| | | | consider surgery." Recommendations: (1) "Stop routine physical therapy and patient to be instructed in home exercise program for the cervical spine and lumbar spine"; (2) "Patient should be seen twice in physical therapy for the home exercise program"; (3) "Would recommend surgical decompression for the cervical spinal stenosis and fusion of the Grade 3 spondylolisthesis when patient is ready for surgery"; (4) "Continue with home exercise program as directed"; (5) "Follow-up will be on an as needed basis"; (6) "I advised patient that I would be most happy to refer her to Dr. Samuelson for consideration of fusion of the lumbar spine and/or a cervical diskectomy and fusion." |
| 10/11/00 R. 217-18 | Michael P. Baker, Ph.D. Associates for Psychological & Therapy Services | DDS mental status exam | Pt reported she was "trying again for disability based on my back and neck." Pt reports "considerable pain when she walks, bends, moves." Pt has seen several doctors and had MRI and neuro consult in 1997, w/pain shots that "helped only for a matter of days. She was told that surgery was possible, but that it could make things worse. Back problems apparently started occurring in 1991." Pt states she had spina bifida at birth. She also reports asthma and allergies for 7-8 years, "but has no insurance or money to go to the doctors for these problems." Pt feels that recently, "she is not so depressed," but she is anxious and reports "very poor sleep." |

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| | | | When not watching her grandson, she arises anywhere between 8:00 and 11:00 a.m. Pt does her own cooking and shopping. Pt denies panic attacks or suicidal ideation. "She admits to numerous crying spells, usually 'by myself.' She reports poor memory. She was able to recall three things after a number of minutes of interview. Concentration also was complained about, but she added, 'maybe it's just that I'm not paying attention.'" Pt's "complaints were rather vague at times." No delusional thinking or looseness of association were detected. She remained focused on the discussion. "By her own report, a generalized anxiety disorder may be appropriate." "Mental limitations might affect her concentration level and attention in maintenance due to the anxiety. She was able to interact appropriately with this evaluator. She's not had a great deal of outside work experience. Ability to remember and understand instructions would not seem limited." Diagnosis: generalized anxiety disorder versus dysthymic disorder. Current GAF of 70 [indicating "mild symptoms or some difficulty with social and occupational functioning," *see* DSM-IV at 32]. |
| 11/07/00<br>R. 219-23 | J.S. Burgfechtel, M.D.<br>Midtown Mercy Medical Clinic | DDS physical exam | Pt reviewed her complaints of pain, numbness, allergies, etc., as set forth in prior entries; Dr. noted she was "a fair historian." "States she believes she can carry light groceries or perhaps a gallon of milk, but even that |

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| | | | may be difficult. She is able to walk 4-6 blocks and sit ½ - 1 hour. She does her own bed and some vacuuming but that is about all the housework she feels capable of." Dr. summarized physical findings as follows: "She appeared to have normal range of motion of her upper extremities, normal grip strength and reflexes in her upper extremities. Sensation and reflexes seem normal. She did have mild grading but normal range of motion in both shoulders. She did have some sensitivity in both lower paracervical muscles and left and right trapezius. Pulses in her feet were palpable. No real atrophic changes or deformities. She did have decreased sensation in her right foot to pinch and light touch as compared to the left, however. Reflexes still seem intact. Knee, hip and ankle range of motion seemed within normal limits. Pelvis had a slight leftward tilt. Some suspicion of a left lumbar or right dorsal curvature relatively mild. She was uncomfortable on palpation in the mid and lower lumbar spine, SI joints and right sciatic notch. Straight leg raising was moderately painful at approximately 60-70" on the right, slightly so at 80-90" on the left. Squat, walking on heels and toes was accomplished though with mild to moderate difficulty. Same with getting on her hands and knees and returning to standing. Romberg was negative." Assessment: (1) "Long-standing cervical and |

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| | | | lumbar pain, presently no definite evidence for radiculopathy from the neck"; (2) "Probable long-standing right sciatica with possible mild to moderate scoliosis/spondylosis"; (3) "Chronic moderate asthma"; (4) "Recurrent anxiety." Dr. opined Pt can lift/carry light weight. "Standing, moving about, walking and sitting are accomplished but are mildly to moderately symptomatic after 30-60 minutes. Stooping, climbing, kneeling and crawling would appear to be poorly tolerated. Handling objects, seeing, hearing, speaking and traveling do not seem obviously impaired. Work environment would be one free of dust, fumes and extremes in temperature regarding her asthma. She did not appear to have any significant extremity joint disease of significance." |

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| 02/12/01<br>R. 141-55 | Dee E. Wright, Ph.D. | Psychiatric Review Technique | Dr. reviewed Record and found Pt not to be disabled due to any mental problem from 09/01/00 through 02/12/01. "The preponderance of the evidence in file establishes the fact the claimant has been evaluated psychologically and is diagnosed with a medically determinable mental impairment - a generalized anxiety disorder (mild) . . . [that] does not appear to create significant restrictions of function for the claimant cognitively, socially, or with activities of daily living from a psychological perspective. The claimant's allegation of disability is credible to the extent that she does have a diagnosed medically determinable mental impairment which is considered non severe at this time." |
| 05/19/01<br>R. 156-65 | Dennis A. Weis, M.D. | Physical Residual Functional Capacity Assessment | Dr. reviewed Record and concluded Pt can lift 20 pounds occasionally and 10 pounds frequently; stand, walk, and sit, with normal breaks, for about 6 hrs in 8-hr workday; no other limitations. Dr. noted "a number of inconsistencies which erode the claimant's credibility," in particular a three-year gap since she obtained or sought medical treatment. He found the consultative exam of 11/7/00 to be consistent with his findings. |
| 05/25/01<br>R. 141 | John C. Garfield, Ph.D. | Psychiatric Review Technique | Dr. reviewed and concurred with Dr. Wright's conclusions (*see* R. 141-55) |